Health Sector Reform Technical Assistance Project (HSRTAP)

CONTRACT COMPLETION REPORT

MARCH 2003

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PROJECT:	**Health Sector Reform Technical Assistance Project (HSRTAP)**
CONTRACT NO:	**HRN-I-00-98-00033-00 Delivery Order No. 804**
PERIOD OF CONTRACT:	**15 June 2000 through 31 January 2003**
CONTRACTOR:	**Management Sciences for Health, Inc.**
SUBMITTED BY:	**Management Sciences for Health HSRTAP Team**
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DATE OF SUBMISSION:	**March 11, 2003**

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LIST OF ACRONYMS

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
AVPC	Average Value per Claim
BFAD	Bureau of Food and Drugs
BHW(s)	Barangay Health Worker(s)
BPR	Business Process Reengineering
CHD	Center for Health Development (formerly Regional Health Office)
CIDA	Canadian International Development Agency
CS	Convergence Site(s)
DBM	Department of Budget and Management
DMS	Drug Management Systems
DOH	Department of Health
DTI	Department of Trade and Industry
EO	Executive Order
FP	Family Planning
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAMIS	Health and Management Information System
HFDP	Health Finance Development Project
HMO	Health Maintenance Organization
HSRA	Health Sector Reform Agenda
HSRTAP	Health Sector Reform Technical Assistance Project
ICHSP	Integrated Community Health Service Project
IEC	Information and Education Campaign
ILHZ	Inter-local Health Zone (used interchangeably with District Health System)
ILO	International Labor Organization
IP	Indigent Program
IPP	Individually-Paying Program
IT	Information Technology
IUD	Intra-uterine Device
LGU	Local Government Unit(s)
MIS	Management Information Systems
MOA	Memorandum of Agreement
MSH	Management Sciences for Health, Inc.

NDP	National Drug Policy
NGO	Non-Government Organization
NHIP	National Health Insurance Program
NTP	National Tuberculosis Control Program
OPB	Outpatient Benefit Package
OPTIONS	Options for Population Policy Project
PCF	PhilHealth Capitation Fund
PCHRD	Philippine Council for Health Research and Development
PDI	Parallel Drug Imports
PHIC/PhilHealth	Philippine Health Insurance Corporation
PhilCAT	Philippine Coalition Against Tuberculosis
PHO	Provincial Health Office
PITC	Philippine International Trading Corporation
PMTAT	Program Management Technical Advisors Team
PNDF	Philippine National Drug Formulary
PRO	PhilHealth Regional Office
PROFIT	Promoting Financial Investments and Transfers Project
PSEP	Personnel Service Enhancement Program
QMMC	Quirino Memorial Medical Center
RA	Republic Act
RH	Reproductive Health
RHIO	Regional Health Insurance Office
RHO	Regional Health Office
RHU	Rural Health Unit(s)
RVS	Relative Value Scale
RVU	Relative Value Unit
SHI	Social Health Insurance
SO	Strategic Objective
SPReAD	Statistics, Policy, and Research Archive and Database
STTA	Short-term Technical Assistance Activity
TA	Technical Assistance
TA	Technical Assistance
TB-DOTS	Tuberculosis Directly Observed Treatment Short Course
TC	Therapeutics Committee(s)
TFGI	The Futures Group International

TOP	Technology of Participation
TQM	Total Quality Management
UPEcon	Foundation of the UP School of Economics
UP-PGH	University of the Philippines – Philippine General Hospital
USAID	United States Agency for International Development
WB	World Bank

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DURATION: June 15, 2000 – January 31, 2003

FUNDING LEVEL: $ 3,703,328

I. Background and Purpose of the Report.

This contract was awarded by the United States Agency for International Development (USAID) to the Management Sciences for Health (MSH) in June 2000, with the Futures Group International, Inc. (TFGI) as subcontractor. Its purpose is to provide technical assistance support to the Health Sector Reform Agenda (HSRA), which the Philippines Department of Health (DOH) launched in 1999 as a program to address the inequalities and inefficiencies in the provision and financing of personal and public health services. The terms of the contract require MSH to organize a Health Sector Reform Technical Assistance Project (HSRTAP) with capabilities to provide various forms of technical assistance to the DOH, the Philippine Health Insurance Corporation (PHIC/PhilHealth), and selected local government units (LGUs) so that they can implement hospital and drug management reforms, improve local health systems, and expand the coverage and benefit spending of the National Health Insurance Program (NHIP)[1]. The original effective dates of the contract were from June 15, 2000 to September 30, 2002. However, the contract end-date was extended to November 30, 2002, and later to January 31, 2003 because there were certain activities that were initiated prior to the original end-date that needed to be pursued further in order to maximize the project's contribution to the health reform effort. The end-date extensions that were granted were at no additional cost to USAID.

This contract completion report summarizes the activities that were undertaken by the project to achieve contract objectives and the results achieved. It is written and submitted in fulfillment of the requirement in Section V.5 of Contract No. HRN-I-00-98-00033-00 Delivery Order No. 804, which stipulates that: "Within 45 days after the contract completion date, the Contractor will submit a final completion report that describes, in summary form, the following:

1. Specific objectives of the contract
2. Activities undertaken to achieve contract objectives and the results achieved

[1] The NHIP is administered by the Philippines Health Insurance Corporation. PhilHealth was established as a government-owned corporation in 1995 with the objective of achieving universal health insurance coverage as well as improved health status. PHIC replaced the Medicare Program, formed in 1972, that provided inpatient hospital insurance for the formal sectors in government and the private sector.

3. Cost of efforts
4. Actions taken to ensure the continuation and sustainability of program objectives
5. Status of these continuing efforts being carried out by the DOH, PHIC, LGUs, non-government organizations (NGOs), other entities.

This report is part of a larger body of technical documents that has been produced and compiled by the project.

II. The Philippines Health Sector Reform Agenda

In 1999, the Philippines DOH took a bold step towards improving the performance of the health sector by improving the way health services are being provided and financed. This program of change, known popularly as the Health Sector Reform Agenda, are directed mainly at a) expanding effective coverage of national and local public health programs; b) increasing access, especially by the poor, to personal health services delivered by both public and private providers; and c) reducing the financial burden on individual families through universal coverage of the NHIP. It consists of five interrelated health reform areas:

1. Local health systems development – Promote the development of local health systems where networking among municipal and provincial health facilities are functional and sustained by cooperation and cost sharing among LGUs in the catchment area.

2. Hospital reforms – Provide fiscal and managerial autonomy to government hospitals, which involves improving the way hospitals are governed and financed so that quality of care is improved, hospital operations are cost efficient, revenues are enhanced and retained, and dependence on direct budget subsidies are reduced.

3. Public health program reforms – Strengthen the capacity of the DOH to exercise technical leadership in disease prevention and control, enhance the effectiveness of local public health delivery systems, and sustain funding for priority public health programs over a period required to remove them as public health threats.

4. Health regulatory reforms – Strengthen capacities of DOH to exercise its regulatory functions to ensure that health products (particularly pharmaceuticals), devices, and facilities are safe, affordable, and of good quality.

5. Social health insurance (SHI) reforms – Expand the coverage and enhance the benefit package of NHIP so as to effectively reduce the financial burden to individual families through effective risk pooling and provide the NHIP greater leverage to ensure value for money in benefit spending.

The HSRA was designed to be implemented as a package because the components are highly interdependent. Success in one area depends on the effective implementation of the other health reforms. For example, hospital reforms will not only improve the quality of care but will also enable hospitals to earn and retain revenues and will allow the redirection of public subsidies to public health programs and strengthening local health systems. Moreover, effective hospital

reforms would help ensure value for money in benefit spending through the NHIP. In turn, universal coverage by the social health insurance program will help secure the financial viability of hospitals as direct subsidies are reduced. Expanding the coverage and benefit spending of NHIP will ultimately reduce dependence of both central and local public health systems on direct public subsidies.

A well-developed local health system where rural health units, and district and provincial hospitals function as an effective network for delivering public health and basic personal health care services will reduce the financial pressure on NHIP from preventable diseases and cases that are best handled by more cost-effective primary level facilities. In turn, an expanding social health insurance program will ensure the financial viability of local health systems over the long term.

The effective delivery of health services requires the availability of affordable and quality drugs and other medical products, equipment, and technology. Thus, the exercise of regulatory functions including standard setting, licensing, and accreditation helps ensure that medical inputs are safe, competitively priced, and of good quality. However, the effective enforcement of health regulations depends on the financial leverage of NHIP, the standards and pricing patterns set by public health facilities, and the ability of the health system to enforce regulations down to the local level.

The above arguments point to a very important technical requirement for a successful HSRA implementation: that ***all five components must be implemented as a single package.***

When it was planned in early 1999, the DOH aimed to achieve nationwide implementation of the health reform program by 2004. As designed, the program would require a massive public investment of around PhP 111 billion. It would also require sustained political commitment and support in order to neutralize the many controversial aspects of the program. Although the reform agenda was planned in early 1999, it was only a year later or in early 2000 that the DOH was able to decide on an implementation strategy and develop an overall implementation plan.

A unique implementation strategy had to be adopted because the major assumptions that formed the bases for planning HSRA in 1999 were no longer valid in 2000. For example, it was no longer realistic to expect that the huge capital outlay required to implement the program was forthcoming because of the increasing budget deficit faced by government, the dwindling external donor support, and the reluctance of government to resort to deficit spending. Furthermore, the political disturbance that began in late 1999 and which eventually led to the downfall of the Estrada administration (which authored and championed the reform program as part of its pro-poor strategy), made it unlikely that the sustained political commitment and support needed for the long-term implementation of the program would continue.

Because of these, the DOH decided that instead of aiming for a nationwide implementation of HSRA by 2004, it would design the implementation of the reform program in such a way as to achieve by 2004 a momentum for health reform that would be difficult to reverse. The strategy adopted was to implement the reform package in selected strategic LGU sites, with the intention

was to generate substantial improvements in health services provision and financing that the residents in these strategically located LGUs could readily appreciate.
It was being theorized that if the residents and political leaders in these sites are happy and satisfied with these improvements, they would form a strong support base that will make HSRA implementation in that locality irreversible. Residents of neighboring provinces and cities, after seeing the health service improvements and financing benefits enjoyed by their neighbors, will pressure their own local governments to grant them the same package of benefits. Thus, through the so-called rippling effect, it could be reasonably expected that the adoption of the health reforms would gradually spread throughout the country. This approach was called the C*onvergence Strategy*, and was the main strategy that the DOH adopted to implement HSRA.

In order to achieve the aimed irreversible momentum, the DOH targeted the application of the convergence strategy in 64 LGUs, or two provinces and two cities in each of the 16 administrative regions, by the year 2004. These LGUs are called convergence sites not only because all the five major health reform components are being implemented in an integrated fashion, but also because all the major stakeholders such as the DOH, PhilHealth, the local government, civil society groups, and the beneficiaries themselves come together and pool their efforts and resources to make the health reforms succeed.

It was originally planned that HSRTAP would directly assist HSRA implementation in 16 of the 64 sites, but the number was later reduced to eight after recognizing the enormity of the effort and resources needed to launch a convergence site. HSRTAP developed the methodology, processes, procedures, and tools for implementing the convergence strategy, which were applied in the eight LGU sites that it was directly assisting. These were constantly refined as experiential knowledge accumulated and was shared with the central and regional DOH offices, which are responsible for attaining the target of establishing 64 HSRA convergence sites by 2004.

III. Specific Objectives of the Contract

USAID agreed with the validity of the HSRA, and believed that it was the appropriate reform package to address the inequities and inefficiencies of the Philippines health care system. It also recognized that HSRA would help achieve the Mission's Strategic Objective 3 (SO 3) of "Reduced Fertility and Improved Maternal and Child Health". However, because of limited resources, USAID technical assistance support to HSRA was narrowed to the following areas:

1. Providing fiscal and management autonomy to government hospitals,

2. Improving the performance of local health systems,

3. Improving the availability (through improved procurement and distribution) of essential drugs and supplies including contraceptives, and

4. Expanding the coverage and improving the benefits of the NHIP.

Originally, there were seven objectives or end-of-project deliverables under this contract, most of which were linked to social health insurance reforms. This was a recognition of the role of NHIP

as the driver of the entire health reform package. The objectives were amended in April 2001 to provide a clearer definition of the deliverables, especially after DOH and PHIC made adjustments to their 1999 baseline figures upon which the contract deliverables were based. Four more deliverables were added to the original seven in July 2002, when USAID extended the end-date for the technical work under this contract to November 30, 2002.

Following are the deliverables of this contract as amended and revised:

1. NHIP benefit package improved to include both inpatient and outpatient services, including Tuberculosis Directly Observe Treatment Schedule (TB DOTS), family health services, family planning, and reproductive health services.

2. NHIP benefits package improved to cover an average of 70% support value of hospitalization costs.

3. NHIP benefit spending increased from PhP 4.2 billion (1999) to at least PhP 10 billion (2002)

4. NHIP coverage increased from 36 million or 47% of total population (2000) to 50.6 million or 65% of total population (2002).

5. Guidelines and manuals of operation for financial management and other management systems for local facilities developed.

6. Each region will have an expansion plan for the Health Passport/PhilHealth Plus Initiative

7. At least one province, city or large municipality in each of the 16 regions is implementing PhilHealth Plus, with quantitative targets for PhilHealth Plus membership and health facilities with Sentrong Sigla certification set and agreed upon by health care stakeholders in the LGU under the leadership of the local chief executive working for university coverage.

8. Each of the eight convergence sites will have a tracking system for outpatient benefits utilization.

9. Overall design developed and pilot testing of outpatient family planning and TB DOTS services initiated.

10. At least one inter-local health zone (ILHZ) in each of the eight convergence sites will be implementing the four health reforms being supported by the project in an integrated fashion.

11. Overall plans for PhilHealth's management information systems development (including organizational development requirements) developed and initiated.

IV. Project Staffing

Management Sciences for Health recruited, hired, and supervised all the technical and administrative staff specified under this contract. The technical staff consisted of: a health insurance advisor who also served as chief of party (COP), a health reform technical coordinator who also served as Deputy Chief of Party (DCOP), a hospital reform manager, a social health insurance reform manager, a drug management system manager, a local health systems development manager, and four technical/program assistants (one for each of the four reform areas that HSRTAP is supporting).

The administrative staff consisted of an administrative and finance manager, an accountant, head of administrative services, head of secretarial services, a senior secretary, a junior secretary, and a driver/messenger. The chart in Figure 1 shows how the project technical and administrative staff was organized.

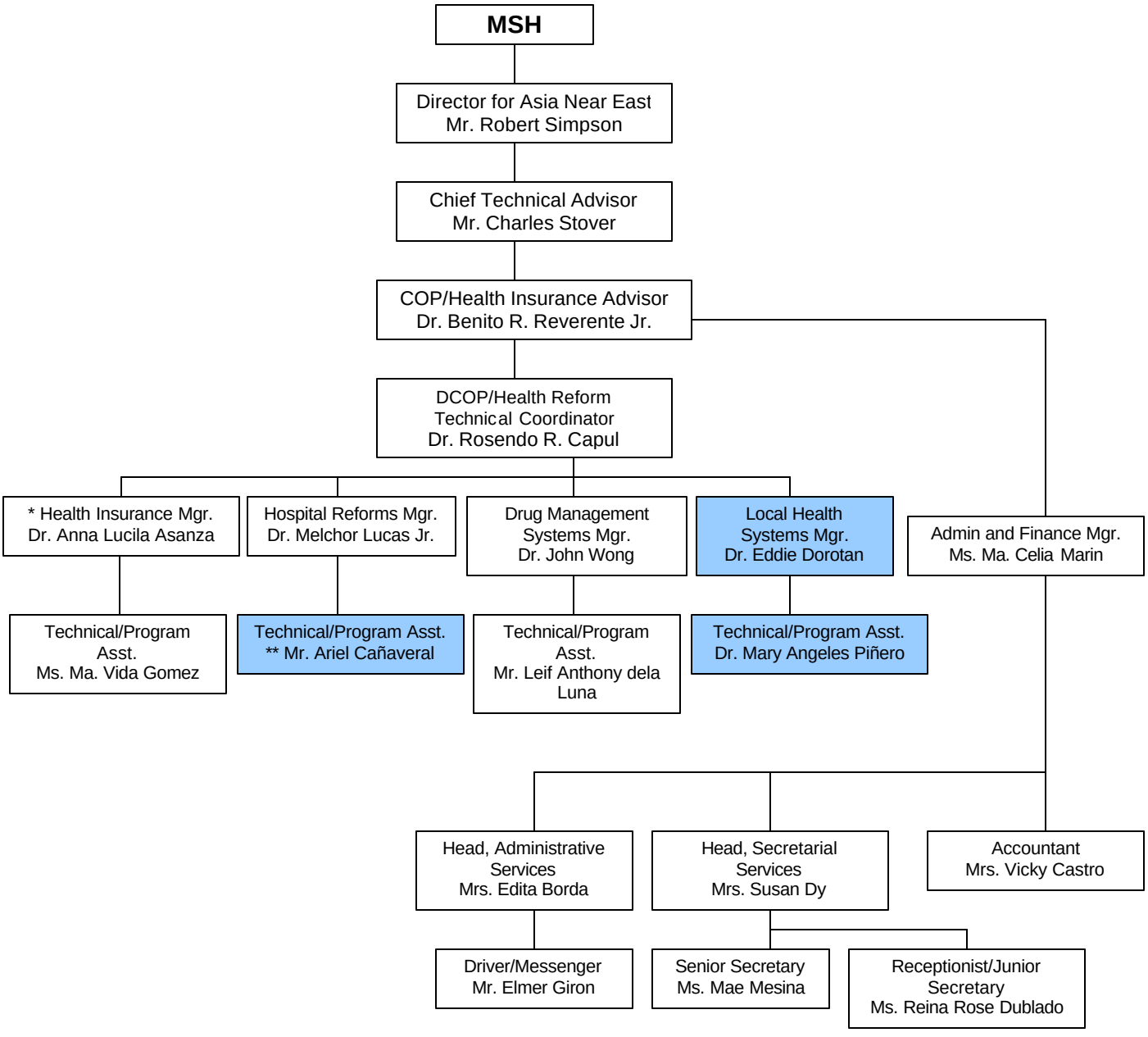
Role of TFGI. TFGI served as a subcontractor to MSH in performing the activities of this contract. Through the subcontract, TFGI provided the local health systems development manager, and the technical/program assistants for hospital reform and local health systems development. Although the salaries and employee benefits of these staff were administered by TFGI, they were nevertheless under the technical and administrative supervision of MSH. TFGI also funded external foreign technical assistance as needed. The subcontracting role helped facilitate the close working relationship between HSRTAP and the staff of the POLICY project team in the Philippines, since TFGI is the prime contractor for POLICY. As a result of that collaboration, the POLICY team assisted in the development of facilitation tools and techniques for the implementation of the convergence strategy, using Technology of Participation (TOP) approaches.

V. Activities Undertaken to Achieve Contract Objectives

The activities undertaken under this contract were all purely in the nature of technical assistance, and were undertaken in support of the implementation of the HSRA, and specifically in order to achieve the eleven contract deliverables. The project had no civil works or sub-granting components, and neither did it undertake any procurement and distribution of commodities.

The technical assistance under this contract was provided either by the project's technical staff, or through the hiring of short-term consultants, both local and foreign, and through local subcontracts. In addition, the project financed health reform training activities, workshops and conferences, inter-local government unit observation visits, one foreign study tour, and the printing and dissemination of technical reports, brochures, and information, education and communication (IEC) materials. These technical assistance activities were undertaken primarily for and with the DOH, PhilHealth, and the eight convergence LGUs (provinces and associated cities).

Figure 1. MSH-HSRTAP ORGANIZATIONAL CHART



* This position was previously held by Ms. Emelina Almario and later by Dr. Ma. Cristina Bautista.

** Replaced by Ms. Joycelyn Abiog as an MSH STTA during the extension period.

The project work plan, which was developed at the start of the project and which was based on the strategies that were deemed to be most appropriate for implementing the different health reform components and for meeting contract objectives, served as the main guide for the activities that the project undertook. Additional guidance was supplied by the set of quarterly deliverables that the project sought to fulfill, and which was jointly formulated by USAID, PhilHealth, DOH, and HSRTAP on a quarterly basis.

The Philippines HSRA and HSRTAP built upon substantial previous work in health financing and reform over the past 15 years, most by donor supported, particularly from USAID. These "predecessor projects" (Table 1) provided a technical platform for the design of the reforms, as well as the platform for HSRTAP's technical assistance activities. HSRTAP deliberately adopted the strategic approach to use previous technical work as a starting point, and to undertake a new technical assistance activity only when earlier work was deemed inadequate to address current needs. This approach, if followed by the implementers of HSRA, will ensure commitment to continued and coherent support to health reforms for a long time.

Table 1. Summary of Current and Previous Health Financing and Reform Projects

PROJECT/ TIMEFRAME	**TECHNICAL FOCUS**	**DONOR/ TECHNICAL GROUP**
Primary Health Care Financing Project	Development and testing of financing schemes to support public health services	USAID
	Various health financing and policy studies	Philippine Institute of Development Studies
	Health Maintenance Organization (HMO) pilots in Laguna and University of the Philippines	Philippine Council for Health Research and Development (PCHRD)
Medicare-HMO Tie-Up	Testing of scheme by Medicare to contract directly with HMOs to include outpatient benefits	Initiated by Medicare Program. Evaluated under Child Survival Project.
HAMIS Project	Community development and health financing initiatives	GTZ
Child Survival Project 1989-1993	Health financing component focused on health insurance, hospital revenues and costing, and public health service costs. Assessment of Medicare-HMO Tie-Up Pilot Scheme Feasibility study for privatization of Philippine Heart Center	USAID through contract with MSH
Health Finance Development Project 1992-1995	Health insurance reform, national and provincial health insurance, hospital services and financing, devolution	USAID through contract with MSH

PROJECT/ TIMEFRAME	TECHNICAL FOCUS	DONOR/ TECHNICAL GROUP
Health Policy Development Project 1992-95	Policy studies and recommendations regarding health financing reform, devolution, DOH mission and activities; direct application of some work to the PhilHealth legislation; design and implementation of national health accounts	USAID under cooperative agreement with UPEcon (Foundation of the University of the Philippines School of Economics)
AMCRA Contract for Systems Improvement	Technical assistance to Medicare on design of key systems and overall requirements (1994-1998)	USAID through contract with AMCRA
OPTIONS Project	Various studies on health insurance	USAID through buy-in to OPTIONS Project
PROFIT Project 1995	Low-cost prepaid health plans managed by PhilamCare for the informal sector	USAID through buy-in to PROFIT Project and agreement with PhilamCare
Women's Health and Nutrition Project		Asian Development Bank (ADB)
Integrated Community Health Service Project	Strengthening local health systems, development of local health accounts, and health care financing systems	ADB/AusAid via contract with Coffey Associates
Integrated Maternal and Child Health Project (PMTAT) 1985-2003	One year of interim support for DOH HSRA agenda in areas of drug management, hospital revenues and autonomy, and health insurance (1999-2000); service delivery strategies in 400 LGUs	USAID through existing contract with MSH
Health Sector Reform Technical Assistance Project 2000-2003	Support to four areas of HSRA reform: Drug Management Hospital Management Local Health Systems Social Health Insurance	USAID through TASC order contract with MSH
World Bank	Technical assistance to prepare a project to finance HSRA implementation in four convergence sites	World Bank (WB) grant to the DOH
Social Reinsurance	International Labor Organization (ILO) negotiating with possible sponsoring organizations to set up a pilot social reinsurance for community-based health financing schemes	ILO and WB Pilot Project

Source: HSRTAP

VI. Work Organization and Methods

In order to appropriately set its direction and ensure proper focus, the project organized its activities in an orderly fashion, and adopted work methods that ensured the attainment of contract objectives and maximized the project's contributions to the health reform program. The main tools and methods that were used were: the preparation of a detailed project work plan, implementing the plan through a flexible quarterly benchmarking system, holding of quarterly benchmark reviews, conduct of short-term technical assistance activities (STTAs), and practice of the team approach.

Detailed Work Plan. The detailed work plan that was prepared at the start of the project consisted of two parts, project management (administrative) and technical. The administrative part detailed the activities that were to be undertaken in order to organize and make functional the system of administrative support to the technical work of the project team. The planned administrative activities were arranged in a matrix that also showed corresponding outcomes and completion timelines, broken by quarter. The technical part, which comprised the bigger portion of the work plan, was divided into the four areas of reform that the project was supporting, namely: social health insurance, drug management systems, local health systems development, and hospital reforms. These were the technical areas that constituted the scope of work of the contract and the bases for the technical staffing of the project.

The work plan for each of the reform areas consisted of three main sections:

1. A narrative section that discussed the rationale for reform, the reform goals and objectives, the strategies employed by the DOH to attain the goals of the reform component, and the role of HSRTAP.

2. A situationer section, which presented in tabular form the activities that needed to be undertaken, by strategy employed, and the focal areas for HSRTAP involvement. It also listed other technical assistance activities that were in progress or planned.

3. An activity timetable that was presented in matrix format. The matrix showed the activities that HSRTAP would undertake, by reform strategy. Each activity indicated the completion timeline broken down by quarter, activity outcome, and involvement of other parties. It also identified the counterpart staff from the collaborating agencies that HSRTAP would be working with.

The work plan was developed collaboratively with counterparts from DOH and PhilHealth, and other collaborating institutions. It was the product of at least five revisions based on discussions with counterparts, internal review, and review by the MSH Senior Technical Advisor. The activity plans were presented to and approved to by the Secretary of Health.

Because they were formulated to be fully responsive to the implementation needs of HSRA, the activity plans were only as clear technically as the level of definition of the Philippines health reform program. When the project started, the real intents of several planned reforms were still unclear, and a number of issues involving policy directions and implementing mechanics needed

sorting out. It was also difficult to pinpoint many implementation responsibilities because the reorganization of the DOH was still ongoing at the time the work plans were prepared. Hence, the project work plan was treated as work in progress, and was revised as lessons were learned, and as the directions of the different elements of the reform program became clearer.

As expected, the work plan was revised and updated in September 2001. The revision was necessitated by three major reasons:

1. The previous changes in the Presidency of the Philippines, the Secretaryship of Health, and Presidency of the Philippine Health Insurance Corporation (PHIC) required adjustments in the plan to meet the priority initiatives of the new administration, and the new style of managing health sector reform activities.

2. USAID reviewed and consolidated its strategic framework for the period 2002-2004, and wanted HSRTAP to take the new directions into account in its work planning, and to clearly demonstrate the linkages between health sector reform activities and the USAID strategic objectives.

3. The method of implementing health sector reforms at that time had shifted from a more heavy focus on activities by the central parts of the DOH and PhilHealth to coordinated activities at the local government unit. This strategy, referred to as the Convergence Strategy, was intended to mobilize the combined resources of provinces and municipalities along with the DOH and PHIC local offices, to implement the reforms at the service delivery level.

Quarterly Performance Benchmarks. The activities in the HSRTAP work plan were implemented in sets of quarterly deliverables. The deliverables were agreed on and reviewed by DOH, PhilHealth, USAID, and HSRTAP at the beginning and end of each quarter. However, a great degree of flexibility was allowed in the formulation of the quarterly benchmarks given the dynamic nature of the reform program. This flexibility made the project capable of responding to strategic shifts in implementing the four areas of reform that the project was supporting. Over the two and a half year life of HSRTAP, it produced a total of 169 deliverables, or an average of 18 deliverables per quarter. The deliverables served as specific evidence that activities were accomplished, and also facilitated early dissemination and application of results.

Quarterly Benchmarking Meetings. An important work method that HSRTAP employed was the holding of quarterly benchmarking meetings. The main purposes of these meetings, which were participated in by key players from DOH, PhilHealth, USAID, HSRTAP, and other stakeholders, were to review the status of achievement of the quarterly deliverables and to plan the deliverables for the succeeding quarter. During these meetings, the DOH, PhilHealth, and HSRTAP, from their individual perspectives, reported on the progress achieved in implementing HSRA, and discussed issues and analyzed problems that constrained progress. The results of these discussions and analyses became the basis for formulating the performance benchmarks for the following quarter.

The benchmarking meetings were initiated during the first quarter of 2001, and became very popular among HSRTAP's counterparts. They served as the forum where reform-minded professionals in and outside the implementing agencies discussed, debated, and monitored the progress of HSRA implementation. This process ensured that

1. HSRTAP was always focused and responsive to the technical assistance needs of the reform program,

2. it was working in full collaboration with its counterparts, and

3. counterparts maintained ownership of the project's technical products, and utilized and applied them to pursue health reforms.

The project prepared quarterly progress reports, which contained a summary of the major health reform events occurring during the quarter under review, progress achieved in HSRA implementation, and the status of achievement of the performance benchmarks. These reports were submitted to USAID and shared with DOH, PhilHealth, and cooperating agencies (CAs) that HSRTAP was closely collaborating with.

Short-Term Technical Assistance (STTA) Activities. STTA activities was HSRTAP's major mode of providing technical assistance to support HSRA implementation. In subcontracting for STTA work, the project employed a stringent process and system that ensured that the resulting technical product was relevant and useful to the reform program, was not a repetition of prior work, was acceptable to the client, and was produced at reasonable cost. The project work plan and HSRA-related technical assistance requests from counterparts served as bases for determining STTA work to be undertaken. The first step that was taken was to ascertain that the problem area to be addressed by the proposed STTA had not been responded to by previous work. A detailed scope of work (SOW) was then prepared that provided information on the purpose and objectives of the activity, required qualifications of consultants, level of effort, consultant's tasks and activities, timelines, and a clear specification of deliverables. Most often the counterpart staff requesting the STTA participated in the writing of the SOW. The requesting office provided formal concurrence on the SOW and the short-list of consultants before they were sent to USAID for review and approval. The strict observance of this process enabled the project to produce technical assistance products of superior quality which have been successfully used to support the implementation of the health reform program.

Assignment of Responsibilities Within the Team. Not only were the scope of work and deliverables of this contract enormous, but the time allotted for their completion was also limited. HSRTAP was able to overcome these limitations by being able to start up rapidly, and by organizing the work of its technical staff in a manner that maximized its efficiency. The four reform area teams were primarily responsible for providing the needed technical assistance support to implement the four reform areas that the project was supporting. In addition, each team was assigned two convergence sites to manage and monitor, and to ensure that all components of HSRA were implemented in the assigned sites. While looking after two convergence sites, a reform area team also made sure that the eight convergence sites implemented its particular reform area. This mode of organizing the responsibilities of the

technical staff likewise emphasized the team approach, which was vital to supporting a reform program whose components are inter-related. Table 2 shows the assignment of responsibilities of HSRTAP technical staff.

Table 2. Assignment of Responsibilities within the Team: Matrix between Technical Areas and Convergence Sites

POSITION(S)	TECHNICAL/ ADMINISTRATIVE FOCUS	CONVERGENCE SITE RESPONSIBILITY BY PROVINCE
Chief of Party/Senior Health Insurance Advisor	Administration, finance, subcontracting, hiring of staff; high level issues in the SHI reform, overall direction of TA for SHI sector	As needed, particularly regarding health insurance strategies
Deputy Chief of Party/ Technical Coordinator	Oversee technical activities of the project; production and quality control of project deliverables; technical supervision of staff	Overall coordination of activities in the eight convergence sites
Administrative/Finance Manager	All financial and administrative operations; local consultancies and subcontracts; banking and cash flow; financial reporting	Administrative support for convergence site activities- travel, workshops, documents
Drug Management Manager/Assistant	Center- support reforms at the Bureau of Food and Drugs (BFAD) and National Drug Policy (NDP) Convergence- pooled procurements, therapeutic committees, parallel drug importation	Capiz Province Pasay City
Hospital Reform Manager Manager/Assistant	Hospital revenue enhancing systems, management systems, organizational and legal models, service quality improvements	Misamis Occidental Province Pangasinan Province
Local Health Systems Manager/Assistant	Develop and strengthen ILHZs, develop and direction of convergence sites strategies, politico-technical strategies; health summits	Negros Oriental Province Nueva Vizcaya Province
Social Health Insurance Manager/Assistant	Strengthen PhilHealth management; information technology (IT) systems support; enrollment of indigents and others; PhilHealth Plus; new benefit packages including outpatient with TB DOTS and family planning	Bulacan Province South Cotabato Province

Source: HSRTAP

Collaboration with Other USAID Cooperating Agreements. HSRTAP worked collaboratively with other USAID cooperating agreements, particularly with the Program Management Technical Assistance Team (PMTAT-MSH), the Policy Project of TFGI, the Johns Hopkins University Communications Project, and Engender Health. HSRTAP coordinated its activities in the convergence sites with PMTAT, particularly in the enrollment of indigent families in the NHIP. PMTAT provided enormous help in the training of Barangay health workers (BHWs) as recruiters of vasectomy and tubal ligation clients for Bindoy (Negros Oriental) and Bailan (Capiz) District Hospitals, and the training of a surgeon from the Bailan hospital on non-scalpel vasectomy. HSRTAP developed the capacities of these two convergence hospitals to enable them to provide surgical sterilization services that are reimbursable under NHIP.

The Policy Project had been a valuable partner of HSRTAP in developing the tools and methods for organizing and conducting convergence workshops. It also helped design courses and conduct training courses, using technology of participation approaches, for central and regional DOH and PhilHealth staff that will organize and facilitate convergence workshops and health summits in the expansion areas. The two projects organized reproductive health advocacy networks and trained health sector reform advocates in Pangasinan and Negros Oriental.

HSRTAP collaborated with the Johns Hopkins University project in planning and organizing the national launch of the HSRA convergence strategy, which has adopted the slogan *Tulong-Sulong sa Kalusugan.* The launch was held successfully at the Malacañang Palace on April 18, 2002.

VII. HSRTAP Working Philosophy

MSH developed the working philosophy for HSRTAP during the proposal stage, and refined it in the presentation of the first work plan, dated September 15, 2000. This philosophy was strictly adhered to, and guided how the project was managed, how it related to its client organizations, and how it produced its work. The philosophy, which is reprinted below, was reiterated in the revised work plan dated September 2001.

"The guiding principle in supporting the Philippines health reform program is that it is going to operate purely as a technical assistance project, and serve as catalyst, consultant, and advisor rather than as direct implementer. The project will support the work of the DOH, PHIC, local government units, and other collaborating agencies and focus on achieving tangible results related to specific targets in the HSRA.

The project will maintain a balance in its work between field-oriented activities and support for central initiatives. While the project focuses its assistance on those activities that will achieve the desired irreversible momentum in order to ensure the continuity of the reform program, it will remain flexible to respond to opportunities brought on by the dynamic nature of health reform. In pursuing the project's work plan, HSRTAP will need to adopt a team approach because of the dynamic inter-relationships among the different areas of reform.

The project will continue to emphasize the use of the most cost-effective methods of providing technical assistance. It will give preference to the use of local consultants and subcontractors. Before starting on a new technical assistance activity, a rigorous check will be made whether similar work had been done before. Similar rigor will be exercised in writing scopes of work and in selecting and monitoring the quality of consultants' performance. While project team members will function as managers of technical assistance and provide some of them, they will strive to train and organize central and regional DOH and PHIC staff to provide similar TA to provinces and municipalities.

Finally, HSRTAP will continue to work in close collaboration with other USAID cooperating agencies and projects such as the Program Management Technical Advisors Team, the Policy Project of the Futures Group, and other donors assisting HSRA."

VIII. Results Achieved

Meeting Specific Objectives of the Contract. Following is a report on the status of achievement of each of the 11 end-of-project deliverables:

1. *NHIP benefit package improved to include both inpatient and outpatient services, including TB DOTS, family health services, family planning, and reproductive health services.*

   PhilHealth benefits currently include both inpatient and an array of outpatient services including family health services, family planning, and reproductive health services. These include surgical sterilization procedures such as vasectomy and bilateral tubal ligation and IUD insertion. In addition, a case rate benefit scheme for the first two normal deliveries and a TB DOTS Benefit Package will be launched in February 2003.

   The inpatient benefits were enhanced in January 2002 by means of an increase in benefit ceilings by about 19% for professional fees, 23% for drugs and medicines, and 28% for x-ray and laboratory services.

   The Relative Value Scale 2001 (RVS 2001) implemented during the first quarter of 2001 paved the way for procedures having a relative value unit (RVU) of 30 and below to be compensable on an outpatient basis, including surgical sterilization procedures and IUD insertion. This is in addition to other outpatient services already previously compensable such as chemotherapy, radiotherapy, hemodialysis, surgical and other procedures with a relative value of 30 and below and those surgical procedures conducted without anesthesia, under local anesthesia, or through intravenous sedation. PhilHealth covers for these outpatient services the professional fees, operating room fee, and drugs and medicines appropriate to an ambulatory setting. Accredited hospitals and ambulatory surgical centers can provide these services to members of the NHIP.

In October 2000, PhilHealth also launched the Outpatient Consultation and Diagnostic Package (OPB) for indigent members with rural health units or city health centers as initial providers. The OPB explored capitation as a mode of payment for service providers. The capitation payment is paid to the local government units owning the health center at PhP 300 per family per year. The OPB covers primary consultation and the following diagnostic and preventive healthcare services:

Diagnostic Services
- Complete blood count
- Fecalysis
- Urinalysis
- Chest x-ray
- Sputum microscopy

Preventive Healthcare Services
- Visual acetic acid screening for cervical cancer
- Regular blood pressure measurements
- Annual digital rectal examination
- Body measurements
- Periodic clinical breast examination
- Counseling for cessation of smoking
- Lifestyle modification counseling

The TB DOTS Benefit Package will initially be implemented among select private TB DOTS Centers and will be expanded by the second or third quarter of 2003.

The PhilHealth Board has also approved for February 2003 implementation a case rate benefit scheme for the first two normal deliveries and all other compensable deliveries of PhilHealth members. The resolution also allows for accredited primary hospitals and outpatient clinics/midwife clinics to provide services for the first two normal deliveries. Prior to this, only the first normal delivery in an inpatient setting is compensated by PhilHealth.

Further Documentation: PhilHealth Board Resolution No. 501, s.2002: Resolution Approving Case Rate Benefit Schemes for the First Two Normal Deliveries and All Other Compensable Deliveries of PhilHealth Members

2. *NHIP benefits package improved to cover an average 70% support value[2] of hospitalization costs.*

As a result of the increase in hospitalization benefit ceilings implemented in January 2002, the support value of hospitalization costs is expected to increase to 68% from an

[2] Support value is defined as the ratio of the portion of hospital bills paid by PhilHealth for each member divided by the total bill. Increasing PhilHealth benefits increases support value. Increasing hospital charges decreases support value. The patient pays the balance between the total hospital charges and the amount paid by PhilHealth.

unofficial estimate of 56% support value. In 2000, it was generally accepted that support value in 1999 was less than 50%.

The unofficial estimate of 56% support value was computed in the middle of 2001. At this time, the average value per claim (AVPC) was PhP 5,424. The new hospitalization benefit schedule in January 2002 increased the benefit ceilings for professional fees, drugs and medicines, and x-ray and laboratory by about 19%, 23%, and 28%, respectively. Since these three cost items comprise 10%, 50%, and 30% of claims, respectively (the remaining 10% consists of room and board which did not merit an increase), the AVPC is effectively increased by 22%. The new expected AVPC is therefore PhP 6,606. This new AVPC translates to a 68% support value, an addition of 12% from 56%.

Records do not yet reflect the actual increase in AVPC as a result of the increase in benefit ceilings effected in January 2002. With a 60- to 90-day lag in payment of claims from actual availment, the change in AVPC is not expected to be observed until the last quarter of 2002 at the earliest.

At present, PhilHealth could not ascertain with a great degree of accuracy the support value. The actual hospital charges are not reported consistently and accurately by the service providers. The database is also found to contain many inconsistencies hence, it is inappropriate to draw firm conclusions from it.

HSRTAP proposed technical assistance to help PhilHealth develop a system of periodically assessing the NHIP support value. PhilHealth, however, declined the offer because in-house efforts were already underway to develop such a system. So far, only rough estimates of support value for 2000 and the first semester of 2001 have been made and caution is again given that the figures are likely to be far from accurate due to inaccuracies in the database.

In the 2000 data analysis, the support value for that year was computed to be 66% if the mean of the support value of all claims is considered, and 51% if aggregate payout is compared against the aggregate hospital bills. A more relevant interpretation of support value for social insurance is the number of claims with a 100% support value. For the 2000 data, this was computed to be 11% of all claims.

More claims with 100% support value, specifically to indigent members, is expected after the DOH released an office order in June 2002, instructing all retained government hospitals (i.e., those under the jurisdiction of the DOH) not to require co-payments for indigent members of the NHIP treated in these hospitals.

3. *NHIP benefit spending increased from PhP 4.2 billion (1999) to at least PhP 10 billion (2002).*

The benefit payouts for 2002 is expected to reach about PhP 9.34 billion. Records show that PhP 6.4 billion has already been paid for the period January to September 2002. This

translates to about PhP 2.13 billion per quarter. The claim payouts for the last quarter of the year is expected to be considerably bigger than in the other quarters since these are payouts mainly for benefit availments in the third quarter. Highest utilization is usually experienced in the third quarter since it coincides with the rainy season. Assuming benefits payout is higher by 15% in the last quarter, this raises expected 4th quarter payouts to PhP 2.45 billion. A higher figure is further anticipated since the resulting increase in AVPC due to the increased benefits cap in January 2002 is expected to be realized. Assuming a conservative 20% increase in benefits due to higher benefit ceilings, final expected benefits payout for the last quarter of 2002 is PhP 2.94 billion, resulting to an expected total benefits payout worth P9.34 billion for the entire 2002.

Table 3. PhilHealth Benefit Payouts, 1999-2002.

Year	Benefit Payouts (PhP thousand)
1999	4,217,691
2000	6,875,172
2001	7,657,840
Jan-Sept 2002	6,393,960
Jan-Dec 2002 *(projected)*	*9,340,000*

Source (excluding projections): PhilHealth Corporate Planning Department

The target PhP 10 billion benefit payout for 2002 was not realized because coverage of second pregnancy and pediatric tuberculosis were not implemented in time. Once these are implemented and the effect of increased benefit ceilings realized, a substantial increase in benefits payout is expected. Additional enrollments will also increase payouts for inpatient and outpatient services, as well as capitation payments for the OPB.

4. *NHIP coverage increased from 36 million or 47% of total population (2000) to 50.6 million or 65% of total population (2002).*

The underlying objective of this deliverable is an increase of about 40% in NHIP coverage over the two-year duration of HSRTAP, which the project met since there is a projected increase in coverage by at least 38% by end of 2002.

The baseline figure of 36 million above no longer holds true after PhilHealth made a downward revision due to adjustments in the family size used. The above statement is also already a revision of the initial target of coverage of 53.65 million beneficiaries or 67.5% of the population in 2002 from 38.16 million or 50% of the population in 2000. Both versions target a 40% increase in coverage.

The table below shows that the enrollment as of September 2002 is about 10 million, equivalent to about 43 million beneficiaries. It is safe to assume that in the last quarter of 2002, the indigent and individually-paying members will still increase by one-third of the achieved enrollment in the first three quarters, resulting to 2.6 million more enrollees or 13 million more beneficiaries. Total projected coverage by yearend is therefore 44

million, which increases coverage by 49% if 29 million beneficiaries is used as the baseline, or 38% if 32 million is used as the baseline.

Table 4. NHIP Coverage, 2000-2002

	2000		2001		as of Sept 2002		end-2002 projections	
Projected Population (based on 1995 census)	76,348,160		77,925,894		79,503,675			
	Members	Estimated Beneficiaries	Members	Estimated Beneficiaries	Members	Estimated Beneficiaries	Members	Estimated Beneficiaries
Indigents and Individually-Paying:								
Indigents	347,016	1,596,274	619,014	2,847,464	1,116,363	5,581,815		
Individually-Paying	430,670	1,907,722	929,589	4,181,648	1,247,116	6,139,618		
Subtotal 1	***777,686***	***3,503,996***	***1,548,603***	***7,029,112***	***2,363,479***	***11,721,433***	***2,635,104***	***13,068,529***
% Increase from 2000			*99*	*101*	*204*	*235*	*239*	
% of Population Covered		***5***		**9**		***15***		
Formal Sector and Pensioners:								
Formal-Government	1,868,215	6,967,111	2,010,801	8,948,003	2,138,447	10,197,408		
Formal-Private	5,292,820	19,125,596	5,291,005	20,767,114	5,076,018	20,204,944		
Pensioners	-	-	477,448	716,172	477,448	716,172		
Subtotal 2	***7,161,035***	***26,092,707***	***7,779,254***	***30,431,289***	***7,691,913***	***31,118,524***	***7,691,913***	***31,118,524***

	2000		2001		As of September 2002		End-2002 projections	
All Member Types:								
Total Estimated Members/ Beneficiaries	**7,938,721**	**29,596,703**	**9,327,857**	**37,460,401**	**10,055,392**	**42,839,957**	**10,323,017**	**44,187,053**
% increase from 2000			*17*	*27*	*27*	*45*	*30*	*49 (38 if baseline is 32 million beneficiaries in 2000)*
% Population Covered		**39**		**48**		**54**		**55**

* If regional distribution for 2000 is patterned in the same manner as in 2001 and 2002, estimated coverage should be about 32 million, or about 42% of population.

Source (excluding projections): PhilHealth Corporate Planning Department

Another underlying objective for this deliverable is reaching 70% coverage by 2004 in order to achieve universal coverage or 85% by 2010. With the 54% coverage as of September 2002 (original baseline coverage is 50% in mid-2000), 70% coverage is a big challenge for 2004, but 85% by 2010 is highly achievable.

5. *Guidelines and manuals of operation for financial management and other management systems for local facilities developed.*

   Five sets of important manuals and guidelines for use of local stakeholders have been developed by the project:

   i. Convergence Planning Design Kit

   This contains pertinent materials that an LGU can use in planning the implementation of the convergence strategy, including activity design for the convergence workshop and the health summit, and a template of the Pledge of Commitment by stakeholders.

   ii. Health Referral Manuals

   Site-specific manuals on the referral system have been developed for the provinces of Negros Oriental, Misamis Occidental, Pangasinan, Nueva Vizcaya and Bulacan and the city of Pasay. They are intended as guidelines and policies in referring the patients to and from different facilities.

   These manuals have been packaged based on the outputs of workshops done which were participated in by different stakeholders. The referral manuals developed by the DOH Integrated Community Health Service Project (ICHSP) and the University of the Philippines-Philippine General Hospital (UP-PGH) were also used as reference materials.

   iii. Toolkit for Establishment and Management of Inter-local Health Zones

   The Toolkit contains the following:

   a. Handbook on Inter-local Health Zones: District Health System in a Devolved Setting

   This manual on organizing and managing ILHZs is a user-friendly guidebook that deals with the principles; the key players; the organizing activities; the legal and political dimensions; the management; financing, and monitoring of inter-local health zones. It has been published and 2,500 copies have been distributed nationwide by the DOH.

   As the Secretary of Health mentioned in the foreword, this handbook should serve as "a management tool for local health officers, local government unit executives and other officials, health personnel in the various levels of local government units, other government and non-government organizations and private entities in aid of the institutionalization of local health systems within the context of local autonomy through collaboration and partnership."

b. Manual on the Financial Management of the Common Fund of Inter-local Health Zones

This manual serves as a guide and tool for policy makers and managers of organized ILHZs in their effective and efficient management of funds allocated by different LGUs to improve the delivery of health services within the health zones. With inputs from the experiences of health zones having common funds, this manual deals on the governance structure and the processes of sourcing and utilizing the common fund of ILHZs.

iv. Toolkit for Management of LGU Hospitals

This Tool Kit contains the following:

a. Hospital Performance Monitoring Tool

The inputs for this tool were derived both from already existing monitoring tools in the DOH and from the innovations undertaken by some LGU hospitals. The tool integrates these and takes a holistic organization approach as it takes into consideration four performance areas vital in any hospital organization: service quality, service volume, costs, and revenues. These four areas are often treated separately and more often than not, costs and revenues are seldom considered measures of performance.

The tool has been introduced and has been positively accepted in all provincial hospitals in the convergence sties.

b. Guidebook for Organizing LGU Hospital Boards

This manual serves as a guide for LGUs that would like to transfer the management of LGU-owned hospitals from the provincial government to a governing board, as an alternative management modality in order to improve services and operational efficiency. The guide outlines the steps to be taken in selecting prospective hospital board members. It also contains a list of competencies to be considered, the terms of office, responsibilities of officers and members, and the relationships of the Board with the major departments of the hospital.

The manual was patterned after the Handbook for Hospital Board Members prepared by the Kenya Ministry of Health and the MSH. Sections of the original handbook were revised to conform with the local environment and operating requirements.

c. Implementation Kit for Government Hospital Corporatization

The kit guides implementers through the different stages of hospital corporatization. It explains the rationale for hospital corporatization and describes the HSRTAP experience in implementing the program. A set of guidelines follows and is grouped into the following: preparatory phase, systems improvement, and legal conversion. The activities in the preparatory phase walk the stakeholder through the different documents that will enable them to understand corporatization. The systems improvement portion helps the hospital focus on the initial systems that need to be strengthened to achieve corporate readiness. The legal conversion portion guides the hospital through the different legal documents and processes.

The kit points the reader to the materials that are available as references. Selected documents are attached as annexes for ease of reference.

d. Manual on Hospital Financial Management

This manual is most useful for public hospitals that will operate as government corporations, and is one of the references cited in the implementation kit for government hospital corporatization in letter c above. It is designed to provide both accounting and financial information that are needed by healthcare managers in order to fulfill the organization's mission and purpose.

The manual will be useful in communicating the financial position of the organization to the Board of Trustees and to outside organizations, including government.

v. *A Drug Manager's Tool Kit*

This is a compilation of manuals and other tools for drug management systems that include the following:

a. Therapeutics Committee Training Course: Session Notes and Visual Aids

b. Managing Procurement: Pooled Procurement and Streamlining of Processes

c. An LGU's Guide to the Purchase of Parallel Drug Imports from the Philippine International Trading Corporation (PITC)

d. Guidelines for Implementing Drug Utilization Review Programs in Hospitals

e. Manual for the Development and Maintenance of Hospital Drug Formularies

Using these tools, an LGU will be able to independently train its therapeutics committee members, develop hospital formularies, develop a pooled procurement

system, purchase parallel drug imports, and implement drug use reviews. All of these acts, taken together, will assure the LGU of quality and affordable drugs that are appropriately used by physicians.

Further Documentation:

- Convergence Planning Design Kit
- Health Referral Manuals of Negros Oriental, Misamis Occidental, Pangasinan, Nueva Vizcaya, Bulacan and Pasay City
- Toolkit for Establishment and Management of Inter-local Health Zones
- Toolkit for Management of LGU Hospitals
- A Drug Manager's Toolkit

6. *At least one province, city, or large municipality in each of the 16 regions is implementing PhilHealth Plus, with quantitative targets for PhilHealth Plus membership and health facilities with Sentrong Sigla certification set and agreed upon by health care stakeholders in the LGU under the leadership of the local chief executive working for universal coverage.*

   PhilHealth Plus is currently being implemented in at least one province, city, or large municipality in each of the 16 regions. Implementation of PhilHealth Plus is also one of the key components in the convergence strategy, which has also been adopted in at least one LGU in each of the 16 regions. In the respective convergence workshops that initiated the convergence strategy in the convergence sites, health stakeholders set quantitative targets for NHIP membership, and PhilHealth accreditation and Sentrong Sigla accreditation of health service facilities.

   PhilHealth Plus combines the inpatient, regular outpatient, and the OPB of PhilHealth. The OPB consists of consultation, diagnostic, and preventive health services provided by PhilHealth-accredited rural health units or city health centers (RHUs/health centers). The health center is compensated by PhilHealth on a capitation basis, in the amount of PhP 300 per family per year.

   PhilHealth Plus is considered implemented in an LGU if these three conditions are present: 1) the indigents are enrolled (through Memorandum of Agreement between the LGU and PhilHealth and payment of premiums), 2) at least one health center is accredited, and 3) an ordinance creating a PhilHealth Capitation Fund (PCF) has been passed by the local council.

   As of October 2002, there were 1,140,034 million families enrolled in the Indigent Program (IP). These enrollments are part of Memoranda of Agreement (MOAs) by PhilHealth and 62 provinces, 100 cities, and 1,164 municipalities, or a total of 1,326 out of 1,689 LGUs nationwide. Also, as of December 2002, there were 361 health centers accredited in 61 provinces and cities.

7. *Each region will have an expansion plan for the Health Passport/PhilHealth Plus Initiative.*

   In May 2002, each PhilHealth Regional Office (PRO) developed an expansion plan for PhilHealth Plus in their respective regions, using the working definition of PhilHealth Plus in Item 6 above.

   Each PRO first assessed the current status of PhilHealth Plus in its respective jurisdictions, and examined its strengths, weaknesses, opportunities, and threats, including its current resources. From here, the PROs mapped out when the rest of the LGUs, at the municipality level, will be implementing PhilHealth Plus. The plan included mapping out for each municipality when groundworking activities will be started and when the milestones of indigent enrollment, RHU accreditation, and passage of PCF ordinance will be realized.

   Four of the 16 PROs targeted more than 90% LGUs implementing PhilHealth Plus by 2004, while two PROs targeted only less than 10% of LGUs implementing by 2004.

   Further Documentation: PhilHealth Plus Expansion Plan for the 16 PhilHealth Regional Offices

8. *Each of the eight convergence sites will have a tracking system for outpatient benefits utilization.*

   A simplified monitoring form for tracking the utilization of the OPB has been developed jointly by PhilHealth and HSRTAP. From these monitoring sheets, PhilHealth can analyze the utilization patterns of indigent members versus non-PhilHealth members, including the frequency of visits, types of diagnosis, and disposition by the health center.

   All PROs have been oriented on the forms and the system. In addition, the health centers in the eight convergence sites have been oriented on the new system.

   For health centers with personal computers operating on Microsoft Windows environment, an electronic version of filling up the forms, developed by HSRTAP consultants, will also be available by first quarter of 2003.

   Further Documentation: Handbook: Guide to Filling-Up OPB Utilization Monitoring Forms

9. *Over-all design developed and pilot testing of outpatient family planning and TB DOTS services initiated.*

   The PhilHealth Board has approved the enhanced reimbursement system for surgical sterilization procedures. On the other hand, the TB DOTS Benefit Package will be launched as a new outpatient package in February 2003.

Surgical sterilization procedures have always been reimbursed on a case rate basis, PhP 900 for vasectomy and PhP 1,125 for bilateral tubal ligation. Initially, surgical sterilization procedures were only covered on an inpatient basis but PhilHealth decided to pilot test reimbursing the procedures on an outpatient basis during the first quarter of 2002. However, very few or no hospitals availed of the ambulatory package for surgical sterilization. To promote the availment of this benefit and encourage accredited health facilities to provide this service, HSRTAP helped establish surgical sterilization service centers in six district hospitals in the convergence sites. These hospitals will be able to perform surgical sterilization procedures on NHIP members and beneficiaries on an outpatient basis, and receive reimbursement from PhilHealth. The Bindoy District Hospital in Negros Oriental began offering this service in October 2002.

Effective November 2002, PhilHealth implemented another enhancement to the surgical sterilization benefit package. These procedures are now reimbursed based on the RVS 2001, with vasectomy and tubal ligation assigned an RUV of 15. This would mean that a hospital can be reimbursed for operating room (OR) use, supplies, and medicines, and physicians/surgeons paid a professional fee of PhP 600 per procedure.

The TB DOTS Benefit Package to be launched in February 2003 will be initially implemented in selected private DOTS Centers as a pilot activity. PhilHealth has designated the Philippine Coalition Against Tuberculosis (PhilCAT) as the technical body that will certify the eligibility of private TB DOTS providers prior to accreditation by PhilHealth. PhilCAT will also be a partner in the monitoring and evaluation of accredited providers particularly regarding provision of quality service and adherence to the Manual of Operations of the National Tuberculosis Control Program (NTP), which formed the basis for designing the benefit package. The accredited TB DOTS provider will be paid in tranches on a case-rate reimbursement basis. The reimbursement will cover consultations, diagnostic examinations, and cost of medicines.

Several preparatory activities have to be completed before a smooth initial implementation or pilot testing of the TB DOTS Benefits Package can be initiated. These include:

i. clarification of the role of PhilCAT and its relationship with PhilHealth,

ii. development and validation of accreditation standards,

iii. formulation of implementing policies and guidelines, and

iv. design of the required management information systems (MIS) support. HSRTAP provided assistance by facilitating meetings to clarify the role of PhilCAT and define its relationship with PhilHealth, and meetings with stakeholders for the formulation of accreditation standards and developing the implementing guidelines for the benefit package. HSRTAP also provided initial inputs in the development of an orientation/training manual for PhilHealth personnel and officers.

Further Documentation:

- Draft (2nd): TB DOTS Policies and Implementing Guidelines
- PhilHealth Circular 34, series 2002: New Payment Scheme for Vasectomy, Tubal Ligation, and Cataract Procedures
- Report on Establishing Surgical Sterility Centers in Five Convergence Hospitals

10. *At least one inter-local health zone in each of the eight convergence sites will be implementing the four health reforms being supported by the project in an integrated fashion.*

At least one ILHZ in each of the eight convergence sites have implemented the four health reforms in an integrated manner. The zones include the Baliuag inter-local health zone in Bulacan, the Bayambang district in Pangasinan, the Bailan district in Capiz, the BINATA (Bindoy, Ayungon, Tayasan) district in Negros Oriental, and the Norala local health development zone in South Cotabato and the Oroquieta zone in Misamis Occidental. The City of Pasay and the province of Nueva Vizcaya are also considered inter-local health zones by themselves.

All zones functional district health systems in that they have signed memoranda of agreement and operational management structures. All zones are also actively implementing the SHI program with most catchment local government units enrolling their indigents to the NHIP. Some RHUs are now availing of the capitation payments from PhilHealth and are now servicing the outpatient benefit package. All the participating provincial and district hospitals in the zones are already implementing various quality service improvements after undergoing quality assurance trainings. About half of the ILHZ core referral hospitals are retaining and utilizing their incomes, while the rest are in different stages of implementing this reform. All core hospitals in these zones have already functional therapeutics committees, which oversee the implementation of rational drug use in their respective facilities. Cheap quality generic and branded medicines are also available in these hospitals through the parallel drug importation program and the pooled procurement system.

The following table summarizes the status of the health reforms in the pilot ILHZs as of November 2002.

Table 5. Status of Health Reforms in Pilot Inter-Local Health Zones in the First Eight Convergence Sites, November 2002

	Baliuag, Bulacan	Bailan, Capiz	Bayambang, Pangasinan	BINATA, Negros Oriental	Norala, South Cotabato	Oroquieta, Misamis Occidental	Nueva Vizcaya	Pasay City
Functional district health system								
¤ MOA	Yes	Yes	Executive Order	Yes	Yes	Yes	Province as one ILHZ	City as one ILHZ
¤ Management Structure	Yes	Yes		Yes	Yes	Yes		
Actively implementing Indigent Program (# indigents enrolled/% of population – as of October 2002)	3,550 (6%)	3,362 (12%)	3,000 (8%)	3,829 (18%)	3,597 (23%)	4,676 (17%)	12,193 (16%)	8,479 (11%)
¤ OPB (# of municipalities with accredited RHUs – as of December 2002)	3 of 5	3 of 4	3 of 5	2 of 3	2 of 2	3 of 5	6 of 15	1 of 1 (all 11 health centers in city accredited)
Hospital improvements	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Income retention and utilization	None yet	None yet	Yes	Yes	None yet	Yes	Yes	In process
Improved drug system for drug selection and procurement								
¤ Therapeutics Committee	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
¤ Cheap drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-

Source: HSRTAP

11. *Overall plans for PhilHealth's management information systems development (including organizational development requirements) developed and initiated.*

PhilHealth has finalized the plans for the development of its MIS and has initiated the implementation of its component activities. Following the failed bid and the results of the study tour to Sacramento, California, PhilHealth is now taking in parallel three tracks for the development of its MIS: 1) review of the failed Request for Proposal (RFP) for the PhilHealth Operations Management Information System, 2) improvement of its legacy systems, and 3) adoption of the Utah Medicaid Managed Care System.

The rebidding of the RFP is the least preferred track by PhilHealth management. Legacy systems improvement was started on an interim basis pending adoption of a more integrated system. This includes exploring the use of web-enabled transactions and the development of an archiving software that would facilitate the retrieval of accurate and reliable information; both have been started with the assistance of HSRTAP.

The Utah system was identified as responsive to the information system requirements of PhilHealth. Negotiations are now underway to acquire it after the legal issues of transferring such system to PhilHealth have been hurdled and yielded a positive result. PhilHealth is currently preparing to send a technical team to the United States to evaluate the Utah system and look at the necessary modifications that need to be made.

On the organizational development requirements, it was decided following the advise of two health insurance consultants that before final reorganization is implemented, a business process reengineering (BPR) should first be conducted wherein current business processes, policies and guidelines, and performance measures will be validated, reviewed, and redesigned in terms of efficiency, effectiveness, and responsiveness to PhilHealth goals and objectives. The BPR for PhilHealth core processes has been completed and the BPR for the non-core processes is underway.

Further Documentation:

- Report: Documentation of Efforts by the Philippine Health Insurance Corporation towards the Development of its Information Technology Systems

- Report: Comparison of Public Domain Systems Adapted for PhilHealth's Needs

- Report: Analysis of Federal Law Governing the Ownership of Medicaid Claims Processing System and its Implications for PhilHealth

- Report: Identifying and Addressing Operational, Technological, and Legal Issues in Present and Potential Web-enabled Transactions of the National Health Insurance Program

- Statistics, Policy, and Research Archive and Database (SPReAD) Users' Manual

- Report: Operations Assessment and Business Process Design and Development of the Core Processes of the Philippine Health Insurance Corporation

Health Reform Accomplishments. In addition to meeting the 11 end-of-project deliverables which were mainly in the area of health insurance reform, the project also achieved the following health reform results:

Drug Management Systems

1. The project developed manuals, templates, and other tools for improving local drug management systems that were applied in the eight convergence sites. These tools cover the formation of therapeutics committees, strengthening drug procurement schemes, and monitoring drug use.

2. The technical assistance that was provided to the DOH program to ensure the quality and reduce the prices of drugs resulted in making available affordable and quality drugs in 83 public hospital outlets through parallel drug importation.

Local Health Systems Development

3. Case studies of five successful local health systems were completed.

4. Twenty-four district health systems (called ILHZs) were organized in seven convergence provinces.

5. Local health systems tools such as manuals for organizing district health systems, and financial management and referral manuals, were developed and were applied in the eight convergence sites.

Hospital Reforms

6. Various legal options to grant fiscal and management autonomy to public hospitals were explored and documented.

7. The project completed the preparation of two Executive Orders, after an exhaustive legal study, to corporatize two DOH hospitals. These have been submitted to the Office of the President for review and signature.

8. Three quality improvement techniques (5S, TQM, Procedures Writing) were applied in all convergence sites provincial hospitals.

9. Revenue enhancement tools, such as costing of services, rate-setting, and billing and collection procedures, were introduced in four convergence provincial hospitals.

Convergence Strategy

10. Eight convergence sites were established, where the five major health sector reform components are implemented as a package.

11. The methodology and tools for organizing convergence workshops and health summits, and for local implementation of health reforms were developed, which the DOH can use to expand the number of convergence sites. A core group from DOH and PhilHealth was also trained on the convergence approach.

Contribution to HSRA Implementation. In October 2002, a review that was undertaken by a team led by Prof. Orville Solon of the U.P. School of Economics concluded that HSRTAP was largely responsible for the modest progress achieved by the Philippines HSRA[3]. The review identified five features of the project that contributed effectively to HSRA implementation: convergence strategy, demand-driven support, having fixed targets but with flexible deliverables, the project as a venue for reform discussions, and top project management committed to health sector reforms.

Although much more time and resources should have been spent on the convergence strategy, the project's work in the eight convergence sites produced positive results. At the site level, the key elements of the HSRA were much more observable and real. Even with only a year's worth of work, the outcome of efforts in building ILHZs, expanding IP enrollment, reforming local hospital systems, and managing local drug procurement have already been felt. Perhaps, more important, the convergence strategy mitigated the adverse effect of political and administrative changes at the national level. Moreover, the results of convergence site development received acknowledgment even from the new DOH top leadership.

The initial demand for MSH-HSRTAP support was from top DOH executives who were committed to health sector reforms. This demand was articulated in the HSRA and its implementation plan and the project was tailor fitted to meet such demand. Although the priorities of the current DOH top management have changed, the HSRA continues to be valid (and declared as such by the DOH) so that the project has remained relevant and useful. Furthermore, MSH-HSRTAP recognized that the HSRA served not just the DOH but multiple clients, particularly the LGUs, PHIC, and even legislators. This provided the opportunity for the project to continue its work by directing its support to these other clients.

A key feature of HSRTAP was that it adopted the very outcomes that the HSRA wanted to produce. This allowed the project to steer itself in the direction of HSRA objectives, even in a rapidly changing political environment. However, the project also built for itself some room for flexibility to adapt to such changes. The key feature here was the rolling annual plan with quarterly set and monitored benchmarks jointly determined with client agencies. This approach, which built on the experience with previous USAID projects like the Child Survival Program and the Health Finance Development Project, became more effective when coupled with close interaction between the project and its client.

[3] A Review of the Contributions of MSH-HSRTAP to the Progress of HSRA Implementation. By Orville Solon, Carlo Panelo, Edwin Gumafelix; December 9, 2002

Beyond its staff and consultants, the project also effectively served as a venue for reform-minded health professionals in and outside the client agencies to discuss, debate, and monitor the progress of HSRA implementation. In doing so, the project was able to sustain the constituency behind HSRA. Moreover, the project also could be seen as a facility to support health sector reform champions inside and outside government.

Finally, the assessment report noted that the drive behind the project could not have been sustained without managers who were committed to the HSRA. This commitment was observed to be consistently strong throughout the life of the project.

Other Accomplishments. The project was able to recruit the administrative and technical staff, and put the project office in operation in a relatively short period of time. The rapid start up enabled HSRTAP to begin its technical work earlier than planned and maximize its accomplishments.

Over the two and a half years of its project life, HSRTAP worked on 169 quarterly deliverables; implemented 83 STTAs; organized and financed 159 workshops; meetings; and training courses; held five benchmarking meetings; and organized one foreign study tour and five inter-LGU visits. It prepared and submitted nine quarterly progress reports to USAID.

HSRTAP generated more than 200 different kinds of technical products. They include analytical reports; case studies; management and organization tools; user manuals; documentation of workshops; meetings and other events; progress reports; presentation materials; brochures; posters; operational work plans; and others. They touch on various aspects of health financing and hospital reforms, drug management systems, and local health systems development. All these products are captured in an interactive CD-ROM, which is widely circulated, so that they can be used as tools to sustain the implementation of the health reform program.

Annex A shows a list of the technical documents produced by HSRTAP from year 2000-2002.

IX. Actions Taken to Ensure Continuation and Sustainability of Program Objectives

The health reforms implemented under this contract, particularly those carried out in the convergence sites, were designed in a manner that ensured their long-term sustainability. The integrated reforms in the convergence sites such as the enrollment of indigents in the NHIP, the provision of the outpatient benefit package, improvement of services and availability and quality of drugs, and strengthening of the local health system, are now being felt and appreciated by the residents and political leaders, so that the momentum of reform will be difficult to reverse. Unlike other projects, HSRTAP did not extend substantial logistical or financial support to the convergence sites that would put at risk the continued implementation of the reforms when the assistance is terminated. The project's technical assistance activities have been driven primarily by its clients, and were implemented collaboratively, so that the clients have developed proprietary interest in the reforms that would increase the likelihood of their being sustained.

An important step that was taken by the DOH to ensure the continuation and sustainability of the reforms supported under this contract was the official adoption of the convergence strategy as the framework to be followed for donor-funded projects. The WB is now preparing a project that will finance reform activities in four convergence sites, and continue central level reforms started by HSRTAP. ADB has likewise approved a US$ 0.6 million technical assistance grant that will prepare a project that would finance the establishment of four or five more convergence sites. GTZ is supporting the implementation of the convergence strategy in Southern Leyte. The Canadian International Development Agency (CIDA), on the other hand, has approved a small project to support convergence site activities in Capiz, in partnership with the Gerry Roxas Foundation.

Just before the close of the project's technical work, HSRTAP organized an assessment-planning workshop involving the core health reform advocates of the eight convergence sites. The purpose of the meeting was to get the participants to assess the progress that has been achieved in implementing health reforms in the convergence sites, and develop plans for sustaining what have been accomplished and attain the goals set for 2004. The workshop was successfully held, and each of the eight sites now has a map that can serve as guide to continue the reforms.

PhilHealth, using its own resources, is pursuing the full development of its IT systems and office reorganization in order to firmly institutionalize the health insurance reforms that it had collaboratively developed with HSRTAP. The manuals, templates, and other tools developed by HSRTAP in the areas of local health systems development, drug management, hospital reform, and social health insurance have been packaged into tool kits and distributed to the eight convergence sites and to the Bureau of Local Health Development. They are very useful instruments not only to sustain the reform activities in the convergence sites, but also to expand the number of sites.

Finally, all the technical documents and other technical materials produced by HSRTAP were organized in an interactive CD-ROM and distributed widely, to serve as a tool to expand the coverage of the reform program. The CD captures all the activities in the convergence areas, implementation tools that have been developed and tested, lessons learned, best practices, and the general three-year experience of implementing the Philippines Health Sector Reform Agenda.

X. *Lessons Learned and Recommendations for the Future*

This contract completion report offers four sets of lessons that have been learned in the course of implementing the HSRTAP. The lessons and recommendations can be applied in the planning and design of future health reform technical assistance projects, and in designing and implementing health reform programs. Lessons learned from the work organization and methods that this project effectively used, and which underlie its successful implementation, are also presented.

Lessons for Future Technical Assistance for Health Sector Reform.[4] The lessons cited in this section are excepted from the report of the external assessment that was done to review the contributions of HSRTAP to the achievement of the HSRA implementation progress. This section summarizes the lessons for future technical assistance for health sector reform by identifying the features of HSRTAP that helped secure its effective contributions to HSRA implementation. The review identified five critical elements: convergence strategy, demand-driven support, having fixed targets but with flexible deliverables, the project as a venue for reform discussions, and top management that is committed to health sector reforms.

Convergence Strategy. Although much more time and resources should have been spent on the convergence strategy, its work in the eight convergence sites delivered the goods for HSRTAP. At the site level, the key elements of the HSRA were much more observable and real. Even with only a little over than a year's worth of work, the outcomes of efforts in building ILHZ, expanding IP enrollment, reforming local hospitals systems and managing local drug procurement have already been felt. But perhaps more importantly, the convergence strategy pursued by the project mitigated the adverse impacts of political and administrative changes at the national level. Moreover, the results of convergence site development effectively serve as evidence that even a timid DOH top leadership cannot ignore.

Demand-driven Project. The initial demand for HSRTAP support was from top DOH management that was committed to pursue health sector reforms. This demand was articulated in the HSRA and its implementation plan and the project was tailor fitted to meet such demand. But while priorities of DOH top management have changed, the HSRA continues to be valid (and declared as such by the DOH) so that the project remained relevant and useful. Furthermore, HSRTAP recognized that the HSRA served multiple client agencies other than the DOH, particularly the LGUs, PHIC, and even legislators. This provided the opportunity for the project to continue its work by directing its support to these other clients.

Fixed Targets, Flexible Benchmarks. A key feature of the way HSRTAP was designed is that it adopted for itself the very outcomes that the HSRA wanted to produce. This allowed the project to steer itself in the direction of HSRA objectives, even in a rapidly changing political environment. But the project also built for itself some room for flexibility to adapt to such changes. The key feature here is the rolling annual plan with quarterly set and monitored benchmarks jointly determined with client agencies. This approach, which builds upon the experience with previous USAID projects like the Child Survival Program and the Health

[4] A Review of the Contributions of MSH-HSRTAP to the Progress of HSRA Implementation. By Orville Solon, Carlo Panelo, Edwin Gumafelix; December 9, 2002

Finance Development Project, becomes more effective when coupled with close interaction between the project and its client.

Venue for Reform-minded Health Professionals. Beyond its staff and consultants, the project also effectively served as a venue for reform-minded health professionals in and outside the client agencies it served to discuss, debate, and monitor the progress of HSRA implementation. In doing so, the project was able to sustain the constituency behind HSRA. Moreover, the project can be seen also as a facility to support health sector reform champions inside and outside government.

Project Management Committed to Reforms. Finally, the drive behind the project could not have been sustained without managers who were committed to the HSRA. It is not too difficult to discern the extent of its commitment. One simply has to read the overview section of every quarterly progress report of the project, which without fail provides insightful accounts of the changing political environment and how the project proposed to cope with these without distracting the project away from its original course.

Lessons regarding Implementation of Health Reforms

The Health Reforms Are Well Designed to Work Together at the Convergence Sites. The HSRA Plan of 1999 provides a sound conceptual framework for integrated health reforms in five areas. The experience at the convergence sites has proven that several, and often all, the areas of reform are compatible and inter-related. When the reforms are implemented effectively, they show positive, measurable results in terms of SHI enrollment, improved benefits and services, better coordination and referrals for public health and curative services, lower costs of drugs, and improved hospital financing and operations.

Central Level Reforms Are More Difficult to Implement, because many are supportive of reforms at the LGU level, rather than benefiting the central level directly. In addition, the jurisdiction for making certain changes is divided between agencies that are not readily receptive to guidance and leadership from the DOH.

The HSRA Reflects the "New Reality" in Government Health Services Responsibility for Delivery and Financing. The LGUs (provinces and municipalities) carry the major responsibility for delivering and financing the bulk of services, with policy guidance from the DOH. The DOH provides technical support, training, and policy direction within its resources, but does not have management control over the LGUs. PhilHealth is emerging as a major financing source for health services. The positive policy link between DOH and PhilHealth, whereby the DOH Secretary chairs the PhilHealth board, helps assure that PhilHealth strategies are focused on improving access and services, both public and private. The specific roles and responsibilities between the different levels of government, and between the DOH and PhilHealth, are still being worked out to provide the most effective balance of responsibilities and resources.

Philhealth Policies of Enrolling Indigents in Urban and Rural Areas Is Most Significant Policy Initiative. By starting its move to achieve universal enrollment by focusing on indigent families, PhilHealth is concentrating resources and improving access to health services for those most in

need. This focus helps shift attention to the health needs of the disadvantaged groups. Many old myths about these groups not being reachable, or integratable into the mainstream health service system, are being challenged. PhilHealth benefits are starting to increase the demand for private as well as public services at the LGU level, thereby contributing to the development of the health care market that includes both public and private providers.

Good Health Can Mean Good Politics at All Levels. In the convergence site strategy, there is an explicit attempt to create a "techno-political" consensus on the reform agenda. Political support for indigent enrollment of indigents at LGU levels has become significant, and therefore hard to reverse. Governors and mayors have endorsed specific goals for enrollment of indigents, as well as integrated health reforms in the convergence sites. Presidential support for Plan 500 (enrollment of 500,000 indigent urban families) and Plan 50 (to reduce the price of essential medicines by 50%) provided important support for achieving these results.

Convergence Site Model Becoming Widespread. DOH and PhilHealth endorsement of the convergence strategy provides the overall mandate to use the convergence model for conducting reforms at the LGU level. The WB, GTZ, and ADB are designing their assistance using this model. This focus helps assure that variations and improvements on a standard approach will be made. The most significant element in the standard approach is the "techno-political" consensus on how reforms should be implemented. There are initial indications that health reforms are consistent and supportive of good governance and development, and that SHI membership provides greater access and empowerment for the poor. If these prove to be true, then there is additional rationale and approach to introduce health reforms through initiatives not directly related to health, such as eco-governance and poverty reduction.

Leadership by Government Officials Is a Critical Element in Success. DOH leadership for HSRA is necessary but not sufficient. Political support by the President has proven to be very important for the success of Plan 500 and Plan 50, but is not present for other reform areas. Financial resources for health are generally not controlled by DOH, but rather by the government budget and financing agencies. Certain extra-DOH policies remain in place despite their adverse effect on health reform, e.g., caps on retention of revenue by government hospitals limit incentives for insurance billing, and hence prolongs dependence on direct government subsidies.

At the provincial and municipal levels, leadership by governors and mayors is critical.

Need to Work Backwards, Ahead, and Sideways. Because health reform activities are complicated, interactive, and political as well as technical in nature, it is necessary to have varied strategies to succeed. Working backwards forces the technical activities to build on previous and current initiatives. Using experienced staff (in implementing agencies and on the project team) from previous initiatives, and as well as the dictum to "do nothing new unless necessary" are two ways to save time and avoid repeating work by focusing backward.

Working ahead using a realistically long time frame for reforms, including the time and effort to create momentum, and to learn what works and what does not, is equally important. Otherwise, a succession of short-term activities can easily fail to achieve lasting reform. Working sideways brings the perspective of mobilizing whatever resources are available and appropriate to

accomplish the objectives. Often, initiatives focus solely on the public sector. Tapping the private sector, helping to stimulate positive market forces, and using the expertise from other sources are important strategies.

Health Reform Lessons Yet to be Learned. There are many critical implementation issues identified in the HSRA from which the lessons have not yet been learned. These are presented here as open items for analysis in future HSRA activities.

How to Speed Up Expansion of the Convergence Sites. The expansion of the convergence sites proceeded more slowly than planned, although still with substantial results. The primary model used direct technical assistance provided by the HSRTAP team and consultants, counterparts in participating agencies, and peer-to-peer exchange visits between LGU participants. The new lessons will come from strategies to involve the private sector and harness market forces where possible, to use PhilHealth enrollment of indigents as a platform for improving other services, mobilization of NGOs and private organizations to support the initiatives, and diffusion of lessons between contiguous LGUs with limited outside STTA. Otherwise, the expansion of the activities of HSRA, and the resulting benefits, will be constrained by TA directly from government agencies or also with the support from donor agencies.

New Paradigms Regarding Hospital Reforms: There is a substantial tension between the high financial requirements of hospitals and the more essential yet less costly public health programs. The perennial battle is to make hospitals more financially independent of government funds that can then be channeled in part to fund public health programs. While this debate continued, new paradigms are emerging in the convergence sites on ways to balance these differing priorities. If these paradigms can be documented, and discussed with high level policy makers, there is the possibility of a new set of policies that reconciles the two, and also addresses hospital reform from a positive rather that negative perspective, can emerge. At present, there is no focal point of leadership on this issue, which is larger than the DOH or LGUs- and is affected by policies of the Department of Budget and Management (DBM) and Department of Finance as well as other agencies.

Speeding up Regulatory Reforms. The slow progress in regulatory reforms, using the example of the BFAD, is hampering innovation and reform in the convergence sites as well as other locations. This slow pace can be ascribed to bureaucratic inertia, limited resources, outdated regulatory models and procedures, and pressure from regulated groups. However, it is also likely to be due in part to lack of appreciation of the LGUs and the consumer public as the true client of the agency, rather than vice versa. If this reverse mindset, which dates from pre-devolution days, is still it place, it is probably a more substantial obstacle than most others.

NHIP Expansion as a Platform for Health Reforms. The principal lesson from the convergence sites is that health reforms work best when implemented together, rather than in isolation. This is because the reform activities take place at the provincial and municipal/city level- where providers and clients interact. Among the many HSRA activities, the most likely to provide ongoing, permanent momentum is the expansion of enrollment in NHIP, starting with indigent families, and then including individually-paying members. NHIP enrollment provides access to inpatient care in public and private hospitals, as well as to evolving outpatient benefits targeted

to the health needs of the poor and underserved. Organizing HSRA activities to help expedite and sustain enrollment is an important support to PhilHealth's initiatives. Once enrolled, the new members can become a platform for targeting important services, stimulating service and supply response from the private sector, and expanding the local market for health services as well. This "two-way" street can and should provide ongoing momentum. Of course, it needs to be accompanied by increasing improvements in PhilHealth systems in response to the expanded and new management demands.

Achieving "Irreversible Momentum" in Health Reforms. Given the high dependence on technical assistance to launch the health reform in the convergence sites, one might think that the task of expanding to other provinces, as well as strengthening and deepening the health reform activities where they have already started is practically impossible. The concept of "irreversible momentum" is useful as a concept of sustainability and progress, as well as innovation in methods. Further work in defining and applying this concept to ongoing efforts may yield important new insights, including reinforcement of some of the lessons mentioned above, such as "good health is good politics" and leveraging reform through NHIP enrollment. Further, there are many routes to introducing the reforms from outside the health sector, given the positive implications of the health reforms for good governance as well as poverty reduction.

Lessons Learned in Work Organization and Methods

HSRTAP was a successful project when measured by such parameters as responsiveness to the development problems intended to be addressed, timeliness of performance, end-user satisfaction, performance of key personnel, quality of technical work, and cost control. The success achieved by HSRTAP was to a large extent due to the work organization and methods it adopted.

In order to be effective, a health sector reform technical assistance project should define its role carefully and adhere to such role firmly. From the start, HSRTAP decided that it would play the role of facilitator, consultant, and advisor, rather than implementer. The recognition of this role forced the project to be driven by the agenda that was set by its clients, and caused it to be responsive to the clients' needs.

The project was able to forge a close and collaborative working relationship with its clients through joint formulation and review of quarterly performance benchmarks, and joint planning and monitoring of the execution of STTA activities. The setting of the quarterly performance benchmarks ensured project accountability, and when formulated and reviewed with clients, likewise assured appropriate project focus and responsiveness to the reform program's technical assistance requirements. These work methods made the clients the owners of the project's technical outputs, and ensured that they were applied and utilized in the implementation of the reform program.

HSRTAP was able to steer a steady course through its project life, and was able to systematically organize its work because it invested in the formulation of a detailed work plan when it started. The plan was of course designed to be flexible so that it could respond to the dynamic nature of the reform program, but it served as the general guide for the project's technical assistance activities. Further guidance was provided through the quarterly performance benchmarks.

The project also learned that the work plan guaranteed the orderly assignment and organization of staff responsibilities and activities. The rigorous review of previous work before starting a new technical assistance activity was not only cost effective, but it also allowed continuous and sustained support to health reform activities.

ANNEX A

LIST OF TECHNICAL REPORTS

Hospital Reforms

Administrative Order

1. Administrative Order No. 51-A S.2000 – Implementing Guidelines on Classification of Patients and on Availment of Medical Social Services in Government Hospitals

Guidebook

1. Draft By-Laws for the Medical Staff of Government Corporate Hospitals
2. A Guidebook on Strategic/Business and Facilities Planning for Individual Hospitals
3. First Draft of the Financial Management Manual for Corporatized Government Hospitals
4. Draft Templates of Legal Documents to Transform the Provincial Hospitals of Capiz and Pangasinan into Public Corporations
5. A Guidebook for LGU Hospital Boards

Inception Report

1. Inception Report of the Change Management Consultant

Manual

1. Draft Final Copy: Financial Management Manual and Revised Financial Assessment Tool
2. A Guidebook for DOH (Retained) Hospital Boards

Plan

1. Alternative Models for Corporatizing Government Hospitals

Study: Legal Opinion

1. Legal Feasibility Study to Use an Executive Order to Corporatize Fabella Memorial Hospital and Davao Medical Center

Summary Report

1. Documentation of Issues and Concerns on Corporate Restructuring of Government Hospitals
2. Update on the Corporatization of Roxas Memorial Provincial Hospital
3. Update on the Corporatization of San Carlos General Hospital

Technical Report

1. Introduction to Negros Oriental's Experience in Income Retention and Utilization
2. A Report on the Process of Initiating Improvements in the Billing and Collection Procedures of the South Cotabato Provincial Hospital
3. Action Plans for the Preventive and Promotive Health Activities in DOH Hospitals
4. Report on the Rate Setting Activities in Bulacan and Misamis Occidental Provincial Hospitals
5. The Process of Finalizing and Submitting for Malacanang Approval the Executive Order for Corporatization of ITRMC QMMC
6. Establishing Surgical Sterilization Centers in the District Hospitals of Bindoy, Negros Oriental and Bailan, Capiz
7. A Report on the Process of Initiating Improvements in the Billing and Collection Procedures of the Pasay City
8. Report on the Process of Developing Concrete Plans for Preventive/Promotive Health Activities in DOH Hospitals

9. The 5S Training in Pasay City General Hospital and Nueva Vizcaya Provincial Hospital
10. A Documentation on the Negros Oriental Hospital Income Retention and Utilization System
11. Options to Attain Hospital Reform in Pangasinan and Capiz
12. Methodology for Collecting Data Requirements for the Hospital Costing Tool
13. Executive Order to Corporatize the Ilocos Training and Regional Medical Center
14. Implementation Kit for Government Hospital Corporatization

Training Report

1. Report on 5S Training in Provincial Hospitals of Three Convergence Sites
2. Ilocos Training and Regional Medical Center Financing Management Training Report

Local Health Systems

Draft Final Report

1. Process Documentation of the Health Sector Reform Agenda and Best Practices in Pasay City
2. Process Documentation of the Health Sector Reform Agenda and Best Practices in Negros Oriental
3. Process Documentation of the Health Sector Reform Agenda and Best Practices in South Cotabato
4. Process Documentation of the Health Sector Reform Agenda and Best Practices in Bulacan
5. Process Documentation of the Health Sector Reform Agenda and Best Practices in Misamis Occidental
6. Process Documentation of the Health Sector Reform Agenda and Best Practices in Pangasinan
7. Process Documentation of the Health Sector Reform Agenda and Best Practices in Nueva Vizcaya
8. Process Documentation of the Health Sector Reform Agenda and Best Practices in Capiz

Draft Report

1. Health Referral Manual of Negros Oriental

Handbook

1. A Handbook on Inter-Local Health Zones

Manual

1. Manual on the Financial Management of the Common Fund of the Inter-Local Health Zone (ILHZ)
2. Inter-Local Health Zone Manual

Power Point Presentations

1. Advocacy Materials for the District Health System

Status Report

1. Local Advocacy Program for Reproductive Health and Family Planning in Pangasinan and Negros Oriental

Summary Report

1. Comparative Analysis of Five Inter-Local Health Zones: Current Practices, Policy, and Program Directions
2. Case Studies on Inter-Local Health Zones (District Health Systems in a Devolved Setting): Local Area Health Development Zones (LAHDZ) in South Cotabato
3. Case Studies on Inter-Local Health Zones (District Health Systems in a Devolved Setting): Sta Bayabas and CVGLJ: Inter-LGU Health Systems in Negros Oriental
4. Case Studies on Inter-Local Health Zones (District Health Systems in a Devolved Setting): Lin'awa Health Zones in Kalinga
5. Case Studies on Inter-Local Health Zones (District Health Systems in a Devolved Setting): The Baliuag Unified Local Health Systems in Bulacan
6. Case Studies on Inter-Local Health Zones (District Health Systems in a Devolved Setting): The Arayat Unified Local Health Systems in Pampanga

Technical Report

1. Local Advocacy Planning Workshop in Negros Oriental
2. Local Advocacy Planning Workshop in Pangasinan
3. Health Referral System Strengthening Workshop in Pangasinan
4. Health Referral System Strengthening Workshop in Bulacan
5. A Report on the Tulong-Sulong Sa Kalusugan Inter-Local Exchange Program (Lakbay-Aral)
6. Inter-LGU Exchange Program- January- June 2002

Training Report

1. Basic Group Facilitation Methods: Technology of Participation; Top 1 Training Report Batch 4
2. Basic Group Facilitation Methods: Technology of Participation; Top 1 Training Report Batch 3
3. Basic Group Facilitation Methods- Technology of Participation (TOP 1)- Training Report- 2nd Batch
4. Basic Group Facilitation Methods- Technology of Participation (TOP 1)- Training Report- 1st Batch

Work Plan

1. Operational Plan for Local Health System Development (2001-2004)

Workshop Report

1. Misamis Oriental Referral System Strengthening Workshop
2. Pasay City Referral System Strengthening Workshop
3. Negros Oriental Referral System Strengthening Workshop
4. Reproductive Health Advocacy Network Development Workshop in Negros Oriental
5. Provincial Forum on FP/RH and Health Sector Reform in Negros Oriental
6. Provincial Forum on FP/RH and Health Sector Reform in Pangasinan
7. Report on Workshops on Inter-Local Health Zones

Drug Management Systems

Guidebook

1. A Local Government Unit’s Guide to the Purchase of Parallel Drug Imports from the Philippine International Trading Corporation (PITC)

Manual

1. Review of the DOH Therapeutics Committee Manual
2. Procurement and Logistics Services (PLS): Drug Procurement Manual

Manuals, Plans

1. A Report on the Drug Management Systems of Bulacan: Rapid Assessment, Training Course, and Operational Plan
2. A Report on the Drug Management Systems of Negros Oriental: Rapid Assessment, Training Course, and Operational Plan

Monitoring System

1. (1) A Monitoring and Evaluation System for LGU Drug Management System Reforms and (2) A Course Syllabus for "Monitoring and Evaluating Drug Management System Reforms"

Plan

1. Operational Plan for the Province of Pangasinan
2. Operational Plan for the Province of Capiz

Preliminary Report

1. Identification of Alternative and Viable Modes of Procuring Contraceptives by the DOH

Status Report

1. A Status Report on the Procurement of Parallel Drug Imports by the Eight HSRTAP Convergence Sites
2. Status Report on the Hiring of a Consultant to Review, Improve and Document Into a Procedural Manual the DOH Bidding and Awarding Process, Including the Technical and Financial Evaluation of Bids (Confidential Report)

Study - Assessment

1. An Assessment of the Drug Management Systems in the Center for Health Development (CHD) for Northern Mindanao: Volume 1: Center for Health Development Office
2. An Assessment of the Drug Management Systems in the Center for Health Development (CHD) for Northern Mindanao: Volume 21: Northern Mindanao Medical Center

Technical Report

1. A Progress Report on the Inclusion of Ethinylestradiol Norgesestrel with 75mg FE in the Philippine National Drug Formulary
2. A Report on the Philippine Health Insurance (PHIC) Drug Price Reference Index
3. An Evaluation Report on the Nueva Vizcaya Drug Procurement Reform Workshop
4. Protocol for Rapid Assessment of the Pharma 50 Project (RAP50)
5. Private Sector Participation in the Parallel Drug Importation Project
6. Quality Assurance Program for Parallel Drug Imports
7. Protocol for Pilot-Testing the Reference Drug Price Index
8. Reference Drug Price Index for the First Quarter 2002
9. A Report Reviewing Current Policy Papers on Contraceptive Prescribing Practices and Tariffs
10. Inclusion of New Contraceptive in the PNDF
11. A Report on the Drug Use Review Module 1 Sessions in Bulacan and in Capiz

12. Purchase Orders (POs) for the Procurement of Parallel Drug Imports (PDI) from the Philippine International Trading Corporation (PITC)
13. A Report on the Drug Procurement Reform Workshop in South Cotabato
14. A Report on the Therapeutic Committee Training in the City of Pasay
15. Drug Management System Expansion Activities in the Inter-Local Health Zones
16. The PhilHealth Drug Price Reference Index: A Description of Developments

Training Report

1. A Report on the Drug Procurement Reform Workshop in the Province of Negros Oriental
2. A Report on the Misamis Occidental Drug Management Systems Training Course
3. A Report on the Nueva Vizcaya Therapeutic Committee Training Course
4. A Report on the South Cotabato Drug Management Systems Training Course
5. A Report on the Capiz Drug Management Systems Training Course
6. A Report on the Drug Management Systems Training of Trainers

Social Health Insurance

Decision Document

1. Pre-Qualification Bids and Awards Committee for Information Technology Resources (PBAC-ITR) Resolution NO. 3, S. 2001

Final Report

1. Consolidated Licensing and Accreditation Survey Program (CLASP) Systems Design for Policy Implementation
2. Alternative Financing Sources for PhilHealth's Indigent Program
3. Actuarial Study on the Planned Changes/Enhancements in the National Health Insurance Program (NHIP)
4. Strategic Options of the Use of Clinical Practice Guidelines (CPG) for the Philippine Health Insurance Corporation (PhilHealth) Volume 1
5. Strategic Options of the Use of Clinical Practice Guidelines (CPG) for the Philippine Health Insurance Corporation (PhilHealth) Volume 2

Handbook

1. PhilHealth Plus Handbook – Draft January 2001
2. A Handbook on Capitation Payment Mechanism for the Outpatient Benefit Package of PhilHealth

Inception Report

1. Inception Report: "Alternative Financing Sources for PhilHealth's Indigent Program (IP)/Plan 500 and Individually-Paying Program (IPP)
2. National Health Insurance Program (NHIP) – Social Marketing Plan for an Urban Area

Manual

1. A Manual for the PhilHealth Capitation Payment Mechanism for the Outpatient Benefit Package of the Indigent Program
2. Expanded Health Passport Operations Manual
3. SPReAD User's Manual

Preliminary Report

1. Design of a Monitoring System for Rural Health Unit Outpatient Benefits

Request for Proposal

1. Operations Management Information System (OMIS) Request for Proposal Document

Scope of Work

1. Scope of Work: Alternative Financing Sources for PhilHealth's Indigent Program (Plan 500) and Individually Paying Program (IPP)
2. Scope of Work: Information Technology Consultancy to Review the Request for Proposal for the Philippines Health Insurance Corporation Information Systems
3. PhilHealth Working Papers on Performance Targets
4. Scope of Work for the Actuarial Study

Technical Progress Report

1. Actuarial Study on Planned Changes/Enhancements in the National Health Insurance Program: First Progress Report

Technical Report

1. A Report on Orientation on Monitoring OPB Utilization for PhilHealth Regional Offices and Rural Health Units in the Eight HSRTAP Convergence Sites
2. PhilHealth Plus Status Update
3. Reports on the Clinical Practice Guidelines (CPG) Options and Protocols
4. Social Marketing Plan for the Implementation of the NHIP
5. Final Report: "Proposed Outpatient Benefit (OPB) Monitoring System for Health Units
6. Third Progress Report: "Actuarial Study on the Planned Changes/Enhancements in the NHIP
7. Handbook on Quick Guide in Accomplishing the OPB Monitoring Forms
8. Training Report on Actuarial Training for Actuary and Statistics Teams of the PhilHealth
9. TB-DOTS Policies and Implementing Guidelines - 2nd Draft
10. Development of a Social Health Insurance Marketing Plan: Revised Technical Proposal
11. PhilHealth Circular 34, Series 2002: New Payment Scheme for Vasectomy, Tubal Ligation and, Cataract Procedures
12. Actuarial Study to Review the Premium Structure in Relation to the Planned Changes/Enhancements in the NHIP - Final Report
13. A Report on Comparison of Public Domain Systems Adapted for PhilHealth's Needs by Collective Solutions Inc.
14. Identifying and Addressing Operational, Technological, and Legal Issues in Present and Potential Web-enabled Transactions of the NHIP - Final Report
15. Joint Special Order for the Creation of CLASP Steering Committee and Technical Working Group
16. Operations Assessment and Business Process Design and Development of the Core Processes of PhilHealth

Workshop Report

1. PhilHealth Plus Assessment and Planning

Workshop Summary

1. PhilHealth Plus Visioning Workshop

2. Summary of Proceedings of Workshops on PhilHealth Plus Design
3. Health Passport Initiative Orientation Workshops for DOH and PhilHealth Regional Offices 7,3 and 11 (12 for PhilHealth)

HSRTAP

Benchmark Meeting

1. Workshop on HSRTAP Deliverables: First and Second Quarters 2001
2. Workshop on HSRTAP Deliverables: Second and Third Quarters 2001
3. Workshop on HSRTAP Deliverables: Third and Fourth Quarters 2001
4. Workshop on HSRTAP Deliverables: First and Second Quarters 2002

Project Work Plan

1. Project Work Plan Update - First Year Work Plan
2. Project Work Plan Update – 1 September 2001 – 30 June 2002 - (August 2001)
3. Project Work Plan Update - 1 September 2001 – 30 June 2002 - (September 2001)
4. Project Work Plan Update - 1 September 2001 – 30 June 2002 - (October 2001)
5. Revised Project Work Plan - 1 January 2001 - 30 June 2002 - (May 2001)

Quarterly Report

1. First Quarterly Performance Report – 15 June to 30 September 2000
2. Second Quarterly Performance Report – 01 October to 31 December 2000
3. Third Quarterly Performance Report – 01 January to 31 March 2001
4. Fourth Quarterly Performance Report - 01 April to 30 June 2001
5. Fifth Quarterly Performance Report – 01 July to 30 September 2001
6. Sixth Quarterly Performance Report – 01 October to 31 December 2001
7. Seventh Quarterly Performance Report – 01 January to 31 March 2002
8. Eight Quarterly Performance Report – 01 April to 30 June 2002
9. Ninth Quarterly Performance Report – 01 July to 30 November 2002

Technical Report

1. Reengineering Monograph